Clinical Protocol for the Early Detection of Colorectal Cancer (CRC)
March 2017

This Clinical Protocol is based upon screening guidelines developed by the U.S. Preventive Services Task Force (2016), the American Cancer Society (2016), and the NCCN Guidelines (2016). Not all acceptable CRC screening tests are utilized by the Michigan Colorectal Cancer Early Detection Program (MCRCEDP).

Table 1: AVERAGE RISK

	Age Range	When to Begin	Screening Type & Recommendation	If negative findings:	If positive findings:
AVERAGE RISK	Age 50-75	Age 50	<u>**At-Home Stool Based Tests**</u> - Guiac-based fecal occult blood test (***high sensitivity gFOBT**) **-** Fecal Immunochemical Test (FIT) **-** DNA-FIT test (Cologuard) ***FOBT or FIT obtained by DRE is not acceptable for screening** <u>**Direct Visualization Tests**</u> Colonoscopy Flexible sigmoidoscopy plus FIT yearly Flexible sigmoidoscopy Computed Tomographic Colonography (CTC)	<u>**Annual Stool Testing**</u> -*gFOBT (high sensitivity) annually or -FIT annually *– DNA-FIT Manufacturer recommended every 3 year* -Colonoscopy every 10 years - FSIG every 10 years <u>plus</u> annual FIT FSIG every 5 years CTC every 5 years	See: Abnormal Result Table or History of Polyps Table
	Age 76-85	The decision to screen should be individualized taking into account the patient's overall health and prior screening history utilizing one of the above recommended CRC screening methods.			

Table 2: INCREASED RISK due to family history

	Family History:		When to Begin	Surveillance Type	If negative findings:	If positive findings:
INCREASED RISK	**Colorectal cancer or polyps**	CRC or adenomatous polyp in one first degree relative (parent, sibling or child) before age 60 OR in two *or* more first degree relatives of *any* age	Age 40 or 10 years before the youngest case in the family, whichever is earlier	Colonoscopy	Every 5 years Counseling to consider genetic counseling and testing for affected relative with referral to a specialist/specialty center	See Abnormal Result Table or History of Polyps Table
		Colorectal cancer or adenomatous polyp in a first-degree relative $\geq$ age 60 OR two second-degree relatives with colorectal cancer at any age	Age 40 years	Any screening option as recommended for average risk individuals	As recommended for average risk persons, depending on type of screening procedure chosen	

Table 3: INCREASED RISK due to personal history of curative-intent resection of CRC

	Personal History of		When to Begin	Surveillance Type	If negative findings:	If positive finding:
INCREASE RISK	**Colorectal Cancer**	**Colorectal Cancer** Personal history of <u>curative-intent</u> resection of CRC	Within 1 year after resection	Colonoscopy	- Colonoscopy in 3 years; if still normal, colonoscopy every 5 years - CRC or other visceral cancers under age 50 should be considered for genetic counseling	See Abnormal Result Table or History of Polyps Table

Table 4: HIGH RISK SCREENING and SURVEILLANCE

		When to Begin	Surveillance Type	If negative findings:	If positive finding:
HIGH RISK	**Inflammatory bowel disease, colitis** (ulcerative colitis or Crohn's)	8 years after the start of colitis	Colonoscopy with biopsies for dysplasia	Every 1-2 years	See Abnormal Result Table or History of Polyps Table
	Personal or Family History of FAP (familial adenomatous polyposis)	Puberty (Age 10-12 years)	Annual FSIG to determine if FAP is present	- If familial polyposis is confirmed, colectomy is indicated; otherwise, endoscopy every 1-2 years - Referral for genetic counseling to specialist/specialty center	
	Personal or Family History of Lynch Syndrome (HNPCC)	Age 20-25 years	Colonoscopy	- Every 1-2 years until age 40, then every year - Referral for genetic counseling to specialist/specialty center	

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Table 5: ABNORMAL TEST RESULT

Abnormal Test Follow-up	Recommended Procedure	Future Screening Protocol
Abnormal Fecal Occult Blood Test (gFOBT/FIT or Stool DNA/FIT) Colonoscopy for <u>any</u> positive FIT/gFOBT or Stool DNA/FIT	Colonoscopy NEVER repeat a + FIT/gFOBT/ or Stool DNA/FIT	Reassess risk status based upon results of colonic exam and follow appropriate future screening protocol.
Abnormal Flexible Sigmoidoscopy	If polyp found and biopsied: <u>Adenoma</u>: colonoscopy <u>Hyperplastic polyp</u>: no colonoscopy, return to screening guidelines **OR** If no biopsy done: colonoscopy	Reassess risk status based upon results of biopsy and follow appropriate protocol.
Abnormal CT Colonography* (*Limited reimbursement in Michigan)	Colonoscopy	Reassess risk status based upon results of the colonoscopy and family/medical history. Follow appropriate protocol.
Abnormal Double Contrast Barium Enema	Colonoscopy	Reassess risk status based upon results of biopsy and follow appropriate protocol.
Abnormal Colonoscopy	Biopsy or Polypectomy	Reassess risk status based upon results of biopsy and follow appropriate protocol.
Incomplete Colonoscopy	Repeat colonoscopy, Double Contrast Barium Enema or CT Colonography	Reassess risk status based upon results and follow appropriate protocol.

Table 6: HISTORY OF POLYPS at Prior Colonoscopy

Type/Number of Polyps	Time of next screening:	Recommended Procedure	Future Screening Protocol
Small, rectal hyperplastic polyps	Time of initial diagnosis	Any screening option as recommended for average risk individuals	Follow average risk recommendations unless hyperplastic polyposis syndrome
Single, small (< 1 cm) adenomatous polyp OR 1-2 small tubular adenomas with low grade dysplasia	5 years after initial polypectomy	Colonoscopy	If normal, consider following average risk recommendations
People with one large (≥ 1 cm) adenoma *or* 3-10 adenomas of any size *or* any adenoma with villous features or high grade dysplasia	3 years after initial polypectomy	Colonoscopy	If normal or 1-2 small tubular adenomas with low-grade dysplasia found, interval may be 5 years
People with more than 10 adenomas on a single exam	< 3 years after initial polypectomy	Colonoscopy	Consider possibility of familial syndrome
Persons with sessile adenomas that are removed piecemeal	2-6 months to verify complete removal	Colonoscopy	Based on endoscopist's judgment. Completeness of removal should be based upon both endoscopic and pathologic assessments

Table 7: SYMPTOM REPORTED by Patient

Symptom Reported by Patient	Age	Recommended Procedure	Future Screening Protocol
Bright red rectal bleeding, on tissue, in bowel, or on stool	Age 50 and up:	Colonoscopy	Reassess risk status based upon results of colonic exam and follow appropriate future screening protocol.
	Age 40-50:	Colonoscopy	
	Below age 40:	If obvious anal source, and no risk factors: treat symptomatically. If recurrent symptoms then colonoscopy or flex sigmoidoscopy.	
Burgundy blood marbled into the stool	Any age	Colonoscopy	Reassess risk status based upon results of colonic exam and follow appropriate future screening protocol.